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In The
Supreme Court of the United States

AETNA HEALTH, INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent, No. 02-1845.

CIGNA HEALTHCARE OF TEXAS, INC.,
and CIGNA CORPORATION,

Petitioners,

v.

RUBY CALAD,

Respondent, No. 03-83.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

BRIEF *AMICUS CURIAE* OF CALIFORNIA CONSUMER HEALTH CARE COUNCIL, CONGRESS OF CALIFORNIA SENIORS AND CALIFORNIA COALITION FOR ETHICAL MENTAL HEALTH CARE IN SUPPORT OF THE RESPONDENTS.

Of Counsel
David Trueman
18 East 50th Street
7th Floor
New York, New York 10022
(212) 758-0093

Eugene R. Anderson
Counsel of Record
Rhonda D. Orin
Daniel J. Healy
ANDERSON KILL & OLICK, LLP
2100 M Street, NW
Suite 650
Washington, DC 20037
(202) 218-0040

Counsel for Amici Curiae
California Consumer Health Care Council, Congress of California Seniors And California Coalition for Ethical Mental Health Care

THE LEX GROUP^{DC} • One Massachusetts Ave., NW • Suite 670 • Washington, DC 20001
(202) 789-2400 • Fax: (202) 789-1911 • www.thelexgroupdc.com

QUESTION PRESENTED

Can ERISA, a statute enacted to protect employees, be used by health insurers and health plans, such as HMOs, MCOs and other health insurance companies, to deny those employees the right to recover against those companies if those companies wrongfully deny employees the medical treatment to which those employees are entitled?

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STATEMENT OF STANDING

Pursuant to Rule 37, a blanket letter of consent from the parties to this appeal has been filed with the Clerk of the Court permitting this brief on behalf of *amici*.[1]

INTEREST OF AMICUS

Founded in April 1995 and incorporated as a California non-profit public benefit corporation in April 1996, the **California Consumer Healthcare Council ("CCHCC")** is a grassroots, volunteer-governed and operated public benefit corporation concerned with protecting the interests of health care consumers throughout California and the United States. The CCHCC is committed to establishing and enhancing health care systems that work well for all Americans. CCHCC advocates, in all available forums, to protect of health care consumers from dangerous, deceptive, dishonest, unlawful or unfair practices. Ensuring that laws designed to protect consumers from improper acts and practices of health insurers and health plans are fully enforced is central to CCHCC's purpose. It is dedicated to preserving and obtaining, through the courts, the power to hold MCOs, HMOs and other insurers accountable for their conduct.

CCHCC has among its constituents, health care consumers affected by limitations on available redress. A diverse range of policyholders from across the United States regularly communicate with CCHCC regarding health insurance claims. Because CCHCC monitors both marketplace developments and policyholders' real life experiences, the organization provides topical information to courts throughout the country via the submission of *amicus curiae* briefs in cases involving insurance principles

[1] Pursuant to Rule 37.6, no counsel for either party has authored this brief in whole or in part and no person or entity has made a monetary contribution to the preparation or submission of this brief.

relating to health care that are likely to impact large segments of the public.

The issues addressed in this case impact health care regulation in California and across the United States and are of immediate and substantial concern to this organization and its constituency.

Congress of California Seniors ("CCS") is a statewide non-profit education and advocacy organization dedicated to improving the life of seniors and their families. CCS devotes its efforts to legislative and consumer affairs that deal primarily with issues concerning older adults. CCS conducts research, analyzes issues and provides voter and consumer education to its members. Through an effective legislative committee, CCS initiates and monitors legislation, testifies at hearings and takes appropriate grass-roots action on pending and proposed legislation. When necessary, CCS initiates or joins in lawsuits to protect consumers and submits *amicus curiae* briefs to provide courts with insights it has learned from its members because of the vast body of real life experience they have acquired. The issues in this case impact, directly and indirectly, its entire constituency. Therefore, CCS is vitally concerned that the Court takes into account the effect its decision will have upon seniors in California and elsewhere across the United States.

California Coalition for Ethical Mental Health Care ("CCEMHC") is a non-profit group composed of mental health clients, family members, advocates, mental health professionals from all the disciplines licensed in California, and other interested members. The organization's mission is to advance access to quality, affordable mental health care through the coordinated efforts of mental health consumers and professionals. It promotes continuity of care, the patients' right to make informed choices when selecting treatment, and elimination of the use of pernicious financial

incentives that limit access to needed care. CCEMHC has an abiding interest in the issue presented in this case because it believes that health insurers and health plans should be held accountable for their treatment decisions and that health plan enrollees need unfettered access to the legal system.

SUMMARY OF ARGUMENT

The Employee Retirement Income Security Act of 1974 ("ERISA") was designed as a shield to protect employees, rather than a sword that to be used against them. This Act, therefore, is turned on its head when health insurers and health plans, such as managed care organizations ("MCOs") and health maintenance organizations ("HMOs") use the Act's preemption provisions to avoid being held accountable for their wrongful delays and denials of coverage. This situation arises all too frequently since, as this Court has acknowledged, health plans have a financial incentive for delaying or denying expensive medical treatment. The instant cases demonstrate the harmful consequences that can result from the misuse of preemption.

The activities of Petitioners Aetna Health, Inc. ("Aetna") and CIGNA Healthcare of Texas, Inc. and CIGNA Corporation (collectively "CIGNA") *may very well* constitute medical malpractice. The U.S. Court of Appeals for the Fifth Circuit properly held that Juan Davila and Ruby Calad are entitled to pursue state claims for malpractice and to be compensated appropriately if they prevail in their claims. The holding that these claims were not preempted is in accord with what even Aetna and CIGNA recognize as the very purpose of ERISA: the protection of employees.

It is not surprising that Aetna and CIGNA, along with the rest of the health insurance industry, argue for a broad reading of the preemption provisions of the ERISA.

A broad reading enables health insurers and health plans to insulate themselves from state tort law claims that could otherwise deter them from delaying or denying treatment incorrectly. Petitioners would have this Court determine that the only consequences they could suffer from a wrongful delay or denial of treatment would be the benefits denied, i.e. the difference in value between the cost of the treatment eventually approved and the cost of the treatment that should have been approved. In other words, the only risk that health insurers and health plans would take, when they delay or deny treatment, is the risk that they would have to pay for it later on.

Such a structure has the inevitable effect of encouraging health insurers and health plans to delay or deny treatment. And that is a serious problem since the profit structure of such organizations provides an incentive to delay or deny treatment in the first place.

Petitioners contend that they are not denying "treatment," but merely are denying "coverage." From the employee's perspective, that is a distinction without a difference. No matter what words are used to couch the denial, the effect is the same: the treatment does not take place.

In fact, the fallacy in this argument is neatly illustrated by the facts of the cases at hand. In each case, the health plan did not merely deny treatment; it proposed an alternative. This Court has already recognized that when a health insurer or health plan denies one kind of treatment and requires a different one instead, it clearly is making treatment – not coverage – decisions.

All treatment decisions should be subject to state tort laws, whether those laws are statutory or at common law. Nothing in ERISA precludes this determination. To the

contrary, ERISA compels it. ERISA plan enrollees should not be deprived of the right to pursue legal claims that could make them whole against health insurers or health plans that wrongfully delay or medical treatment. Health insurers and health plans should not be allowed to insulate themselves from liability for any injuries that they cause. Courts should be allowed to consider whether such practices constitute medical malpractice, bad faith claims handling or another tort. There should be checks and balances on the built-in financial incentive that health plans and health insurers have to delay or expensive treatments, and to favor cheaper treatments – or no treatments at all.

For these reasons, Amici respectfully submit that the Fifth Circuit properly held that ERISA does not preempt state law tort claims, whether statutory or common law, under Section 502(a), 29 U.S.C. § 1132(a) and that this Court should affirm that court's decision.

LEGAL ARGUMENT

I. HEALTH INSURERS AND HEALTH PLANS SHOULD BE HELD ACCOUNTABLE UNDER STATE TORT LAW WHEN THEY CAUSE HARM BY WRONGFULLY DENYING MEDICAL TREATMENT

Under ERISA, health insurers and health plans are allowed to administer health plans for the benefit of enrollees.[2] Typically, they have the authority to approve or deny coverage for treatments that are recommended by the enrollees' treating physicians. This is the point where coverage decisions and treatment decisions converge. As a

[2] Enrollees of an ERISA plan for health insurance are, as beneficiaries of the ERISA plan, in essentially the same shoes as the policyholder in an ordinary insurance context. As such, the enrollee, like the policyholder, suffers the consequences of a denied claim. Further, enrollees pay fees, just like traditional premiums, for the health insurance.

practical matter, from an enrollee's perspective, a denial of "coverage" means that the enrollee does not receive the recommended treatment.

The essential issue here is whether a denial by a health insurer or health plan should be subject to state tort law remedies, both statutory and common law. Petitioners, along with the health insurance industry, say no, on the premise that a denial of coverage is a purely administrative decision that falls within the preemption provisions of ERISA. They say that the only recourse is the ERISA equivalent of breach of contract and the only remedy that should be allowed is payment for the treatment that was denied. Enrollees like Mr. Davila and Ms. Calad say yes, on the ground that such denials are medical, not administrative, decisions. They say that they should have recourse under state tort law for wrongful denials that cause them harm, and that they are entitled to all remedies that state tort law allows.

A. Improper Denials Cause Harm to Enrollees By Adversely Affecting Their Health And Also By Denying Them The Value of the Enrollee's Premium Payments

1. Aetna Denied the Medicine Recommended by Mr. Davila's Treating Physician and Prescribed An Ill-Fated Alternative

It is undisputed, in the case of Mr. Davila, that Mr. Davila's treating physician had prescribed Vioxx for Mr. Davila, that Aetna refused to pay for it, and that Aetna provided a generic painkiller instead. Aetna has admitted all of these essential facts.[3] Mr. Davila took the generic drug prescribed by Aetna and suffered bleeding ulcers as a result.

[3] See Brief for Petitioner Aetna Health, Inc. (Dec. 18, 2003) at 8-10 (characterizing the allegations in Mr. Davila's complaint).

Now, he cannot take any painkillers requiring absorption through his stomach – not even Vioxx, the drug his treating physician had prescribed. Thus, Aetna's so-called "coverage" decision failed to treat Mr. Davila's health problem and may have worsened it instead.

Aetna takes the position that, due to the preemption provisions of ERISA, Mr. Davila would not be allowed to sue Aetna even if Aetna had denied treatment to him in error and tortuously. Aetna contends that Mr. Davila's only available remedy is reimbursement of the price of the Vioxx that had been prescribed, less the price that Aetna paid for the generic drug. As noted by Aetna, this is the only remedy that ERISA would allow.

From an enrollee's perspective, such relief obviously would be insufficient. It certainly would not make Mr. Davila whole. It also would not deter wrongful denials in the future; to the contrary, it would affirmatively encourage health insurers and health plans to engage in wrongful denials. Thus, this case neatly illustrates the need to curtail preemption and thereby to prevent health insurers like Aetna from using ERISA as a sword against their policyholders.

2. CIGNA Denied the Hospitalization Recommended by Ms. Calad's Treating Physician, and She Promptly Suffered Medical Complications.

CIGNA, through a discharge nurse, refused to approve the request of Ms. Calad's treating surgeon to permit her to remain hospitalized after undergoing a hysterectomy involving rectal, bladder and vaginal repair. Instead, the nurse prescribed, or ordered, a discharge from the hospital. Shortly after CIGNA's nurse ordered Ms. Calad to be discharged, Ms. Calad was readmitted under

emergency conditions to treat complications from her surgery.[4]

CIGNA, like Aetna, now contends that the only remedy that can be sought by Ms. Calad is reimbursement of the cost of the hospitalization time that was denied. But, like Mr. Davila, Ms. Calad would not be made whole by such reimbursement. The injury to Ms. Calad goes beyond the cost of the denied hospital time. It includes the adverse health consequences that she suffered as a result of CIGNA's refusal to pay for it, and its provision of a wholly unacceptable alternative. As with Mr. Davila's case, this case illustrates why CIGNA should not be allowed to use preemption as a sword.

B. ERISA Plan Enrollees Need A Remedy That Correctly Addresses The Harms that They Suffer As A Result of Wrongful Denials.

When health insurers and health plans make improper treatment decisions, they should be subject to liability for the harm that they cause. The only way to hold them fully accountable is to subject them to state tort law claims, filed by the enrollees who allege that they were harmed. Administrative remedies under ERISA simply are not enough.[5]

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[4] See Brief for Petitioners CIGNA Healthcare of Texas, Inc. and CIGNA Corporation (Dec. 18, 2003) at 3-4 (characterizing the allegations in Ms. Calad's complaint).

[5] If no tort claim may be brought, then no extra-contractual damages may be sought or recovered. Under ERISA's remedies, an enrollee seeking relief after a treatment denial by bringing an action for benefits due under the plan or for "appropriate equitable relief" and attorneys' fees. See 29 U.S.C. § 1132(a)(1)(b).

1. ERISA Does Not Permit Tort Claims Or Compensatory Damages

Statutory remedies under ERISA are narrowly drawn. Neither tort claims nor compensatory damages fall within the scope of the statute:

> [U]nder ERISA, there is no right to extracontractual damages or punitive damages .... The law is also clear that there is no right to a jury trial.[6]

It makes economic sense for health insurers and health plans to argue that ERISA has as broad a scope as possible "because the only relief available to an ERISA claimant is equitable relief, for which no right to jury trial exists."[7]

When an enrollee's complaints fall under the scope of ERISA, a health insurer or health plan can anticipate the potential value of its denial of a claim at the time the claim is denied. The potential remedy would be completely confined to reimbursement of the value of the treatment that was denied, reduced by the value of the treatment – if any – that actually was provided.[8] Such an approach may have

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[6] Allen, Elizabeth, P., *Long Term Care Insurance Litigation*, FOR THE DEFENSE (February 2003) at 25. FOR THE DEFENSE is a publication by and for attorneys who regularly represent insurance companies.

[7] Rapoport, Simeon, D. and Somervell, Katherine, S., *ERISA Trials Demystified*, FOR THE DEFENSE (February 2003) at 37.

[8] In effect, there would be little downside, and many potential advantages, for a health insurer or health plan to delay or expensive medical treatment. At worst, the damages will be the difference between the cost of the treatment approved or prescribed and the cost of the treatment originally sought by the enrollee – which would be nothing more than the amount that the health insurer or health plan had refused to pay in the first place. Many health insurers and health plans – when faced with a choice between pay-now-or-pay-later-(maybe) – simply would opt for the latter.

served valuable purposes in connection with the drafting of ERISA in 1974, especially considering that the statute's initial focus involved financial matters, such as the management of retirement benefit plans. Yet it is completely inappropriate in the context of health care, especially when the wrongful decisions for which a remedy is being sought concern vital and sometimes lifesaving medical treatment.

Additionally, applying such an approach to the denial of medical treatment and health care runs counter to the overall intent and purpose of ERISA.[9] The beneficiaries

[9] The use of ERISA preemption to deny claims brought by employees who have been denied medical treatment achieves the opposite affect intended by Congress when it enacted ERISA. See DeBofsky, Mark, D., Op-Ed Article, 30 THE INSURANCE FORUM 176. With regard to health care denials, the article states:

> • *Health Insurance.* The ERISA law is cited on a nearly daily basis to shield insurance companies from liability for denying life-saving medical treatment. So long as the insurer writes language into its policy stating that the insurer has discretion to decide who qualifies for benefits and under what circumstances, life and death decisions are insulated from meaningful judicial review. Even if the insurer is later found wrong, the absence of a damages remedy prevents lawsuits to redress the harm committed when a claimant dies as a result of being denied a prescribed life-saving treatment or a mother experiences the wrongful death of a prematurely born newborn infant because the insurer denies prenatal hospitalization.

DeBofsky goes on to point out that:

> Claimants are denied the right to trial by jury, a basic right afforded in insurance cases and virtually all other civil litigation. In most cases, claimants cannot even secure a trial before a judge since the case is decided based solely on the claim record applying procedures that favor the insurers both as to the interpretation of policy provisions as well as the manner in which evidence is reviewed. Employees also have no claim to any damages; no matter how egregious the insurer's or employer's conduct, the maximum recovery available is

who are supposed to benefit from ERISA are the enrollees, the employees, not the health insurance industry. This approach, however, principally benefits the latter, rather than the former.

C. Tort Claims Provide Much More Protection for Enrollees Than Statutory Remedies Provide Under ERISA – Especially When Consideration is Given to the Deterrent Effect

As explained above, this Court has recognized the inherent conflict within the business model of most health insurers and health plans. The conflict is that the business model establishes a financial disincentive for approving expensive medical treatment.[10] One way, and perhaps the only way, to balance out this financial disincentive is to create another financial disincentive for delaying or denying coverage wrongfully. That is what is created by the decision to allow ERISA enrollees to sue their health insurers and health plans in state court, and under state tort law, for wrongful coverage denials.

Indeed, tort claims have historically provided a deterrent to wrongful actions by insurance companies.

> the benefit sought plus the possibility of attorneys' fees awarded in the court's discretion. Thus, the worst that can happen to an insurer that withholds benefit payments, often for years after they are due, is that a court *may* require the benefits to be paid. No damages whatsoever are available for the harm caused as the result of wrongful withholding of benefits such as bankruptcy, home foreclosure, or even death if necessary medical treatment is denied.

[10] Pegram v. Herdrich, 530 U.S. 211, 234, 120 S. Ct. 2143, 2157 (2000) (recognizing that an HMO or HMO physician making a determine about medical treatment for a beneficiary must consider the for-profit incentive of sparingly providing treatment and that such a situation presents a conflict for the HMO or its physician).

Years ago, Richard Ellis, vice-president of claims at Mutual of Omaha Insurance Co., acknowledged that the insurance industry works hard to avoid being exposed to negative jury verdicts and judicial decisions:

> We're somewhat in a posture of doctor practicing defensive medicine . . . we're finding insurance companies paying claims and large settlements simply because of their fear of punitive -damage awards.[11]

Were there to be no opportunity for enrollees even to seek compensatory damages when a health insurer or health plan wrongly denied medical treatment, those companies would have every incentive to delay or claims and there would be no true check on that ability. The threat of liability under state tort law is necessary to provide that check and to ensure that enrollees have a way to deter health insurers and health plans from engaging in wrongful medical treatment determinations.

II. IF RESPONDENTS' STATE LAW TORT CLAIMS ARE HELD PREEMPTED, ENROLLEES WILL BE SUBJECT TO DENIALS OF TREATMENT WITHOUT RECOURSE

A. As Treatment Decisions, Or Mixed Decisions Of Eligibility And Treatment, The Petitioners' Decisions Are Not Preempted

Because ERISA does not preempt either (1) treatment decisions or (2) mixed eligibility and treatment decisions,[12] the simple issue here is whether the decisions made by

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[11] *Business Week*, August 15, 1983, pp. 118, 119.

[12] Pegram, 530 U.S. 211, 120 S. Ct. 2143.

Petitioners, Aetna and CIGNA, fall into either category. The simple answer is that they do.

Treatment decisions answer the question: "given a patient's constellation of symptoms, what is the appropriate medical response?"[13] Here, Aetna refused to approve the medicine prescribed by Mr. Davila's treating physician and provided an alternative instead.[14] Likewise, CIGNA, through a discharge nurse, refused to approve the treatment decision of Ms. Calad's treating surgeon and instead prescribed a discharge from the hospital.[15]

These factual scenarios are analogous to another case involving a mixed decision of treatment and eligibility that was held not preempted.[16] The HMO there, Vytra, and the HMO physician, Dr. Spears, examined an enrollee's "constellation of symptoms" and determined, ultimately, that the appropriate medical response was a single stem-cell transplant, not the double stem-cell transplant selected by Carmine Cicio's treating oncologist. This decision was held to constitute a mixed eligibility and treatment decision within the meaning of Pegram. It was found necessarily to require medical decision-making, as Vytra and Dr. Spears

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[13] Pegram, 530 U.S. at 228, 120 S. Ct. at 2154.

[14] See Brief for Petitioner Aetna Health, Inc., at 8-10.

[15] See Brief for Petitioners CIGNA Healthcare of Texas, Inc. and CIGNA Corporation, at 3-4.

[16] See Cicio v. John Does 1-8, 321 F.3d 83 (2d Cir. 2003), petition for cert. filed, 72 USLW 3093 (July 11, 2003)(No. 03-69)(refusing to hold that common law medical malpractice claims based on an HMOs refusal of a double stem-cell transplant and the HMOs prescription of a single stem-cell transplant were preempted by ERISA). "Pegram demonstrates that the mere presence of an administrative component in a health care decision no longer has determinative significance for purposes of preemption analysis when the decision also has a medical component". Id. at 103.

decided on, then approved, a treatment that the treating physician had not recommended in the first place.

Aetna and CIGNA, in each respective instance, made an entirely separate "mixed eligibility and treatment decision" when they decided that Mr. Davila and Ms. Calad, respectively, should not receive the treatment that was recommended by their respective treating physicians. Each decision clearly incorporated treatment issues.[17] Just as in Cicio, the health insurers and health plans in these cases not only denied a particular treatment, but provided a patient-specific prescription by authorizing another treatment that had not been requested.[18]

These decisions also are comparable to decisions that were made by U.S Healthcare in another case, in connection with the treatment of Basile Pappas.[19] U.S. Healthcare, as plan administrator of Mr. Pappas' health plan, initially rejected a treatment recommendation made by the treating physicians: transfer to, and perform surgery at, a hospital that specialized in spinal cord injuries. After some delay, a transfer to a different hospital was approved instead. The Pennsylvania Supreme Court held that U.S Healthcare's

[17] See Pegram, 530 U.S. at 230, 120 S. Ct. at 2155.

[18] See Cicio, 321 F.3d at 104-05 ("Dr. Spears apparently made a patient-specific prescription of appropriate treatment by denying one treatment and authorizing another that [the treating oncologist] had not requested....we cannot identify distinct moments at which treatment decision as distinct from eligibility decisions were made").

[19] See Pappas v. Asbel, 768 A.2d 1089 (Pa. 2001), cert. denied, U.S. Healthcare Sys. of PA v. Pennsylvania Hosp. Ins. Co., 536 U.S. 938, 122 S. Ct. 2618 (2002).

decisions constituted "mixed eligibility and treatment decisions."[20]

Thus, the plain language of Pegram, combined with the similarities between the decision-making here and in Cicio and Pappas, makes clear that the decisions here involve treatment decisions. For these reasons, Amici respectfully submit that the Fifth Circuit properly held that ERISA does not preempt state law tort claims, whether statutory or common law, under Section 502(a), 29 U.S.C. § 1132(a), and that this Court should affirm that court's decision.

1. It Is Not A Defense That Aetna or CIGNA Claims They Were Only Performing Utilization Review

Aetna and CIGNA both argue that their respective decisions regarding Mr. Davila's and Ms. Calad's respective treatment involve coverage only, as they were made in the course of utilization review.[21] This argument is completely wrong. In short, whenever physicians or managed care organizations make decisions about the treatment that patients should receive, they are making treatment-related decisions. Health insurers and health plans should not be able to evade responsibility for the consequences of such decisions by engaging in an exercise in semantics: i.e., by

[20] Id. 768 A.2d at 1096. "[T]he treating physician did not, in the Supreme Court's words, only make a "'simply yes or no' decision as to whether Pappas' condition was covered; it clearly was. Rather [he] also determined where and, under the circumstances, when Pappas' epidural abscess would be treated. His was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed, as Pegram teaches, through state medical malpractice law." Id.

[21] See Brief for Petitioners CIGNA Healthcare of Texas, Inc. and CIGNA Corporation, at 3-4, and Brief for Petitioner Aetna Health, Inc., at 8-10.

simply saying these decisions regard coverage rather than treatment.[22]

B. Traditional State Tort Claims Are Not Preempted By ERISA, But Compliment ERISA

Pegram makes clear that "treatment decisions" and "mixed eligibility and treatment decisions" are subject to state law, and are not preempted by ERISA.[23] This analysis comports with prior holdings that the "historic police powers of the state include the regulation of matters of health and safety,"[24] and that "the historic police powers of the states were not to be superseded by the federal act [ERISA] unless that was the clear and manifest purpose of Congress."[25]

[22] In a hearing before Congress in 1999, the American Medical Association (the "AMA") stated that "medical necessity decisions are ultimately medical decisions and should continue to be treated as such. [They] must always be made in accordance with those generally accepted standards of medical practice that a prudent physician would follow when treating a patient." Employer Health Plan Accountability: Do Plan Participants Have Adequate Protections?: Hearing Before the House Subcomm. on Employer-Employee Relations, House Comm. on Educ. and the Workforce, 106th Cong. 127 (1999) (Statement of Timothy T. Flaherty, M.D., American Medical Association). Available at http://commdocs.house.gov/committees/edu/hedcew6-24.000/hedcew6-24.htm.

[23] Pegram, 530 U.S. at 235, 120 S. Ct. at 2157-58.

[24] See DeBuono v. NYSA-ILSA Medical & Clinical Services Fund, 520 U.S. 806 (1997).

[25] N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 653-655 (1995). Clipping the wing of the state judiciary is inconsistent with the McCarran-Ferguson Act. The state judicial system is in place to punish insurance companies for wrongful conduct and provide relief for injured parties.

The Savings Clause of the United States Constitution itself protects the states' historic powers and also applies to the ERISA. The Savings Clause necessarily limits implied preemption under ERISA § 502 and state law remedies protected by the Savings Clause would defeat implied preemption under § 502.[26]

ERISA does not provide that Congress intended to preempt state law in the traditionally state-regulated area of health and safety.[27] There is no provision in ERISA that states that it preempts every state law claim relating to ERISA plans.[28] Professor Bogan further points out that both § 502(a) and § 514 are part of the same sub-section and that § 514 provides that "'nothing in this sub-section of ERISA shall be construed' to preempt state insurance regulations."[29]

[26] Bogan, Donald, T., *Fifteen Reasons Why ERISA Does Not Preempt State Law Bad Faith Claims*, ATLA TRIAL MAGAZINE, XXXIV, 4 (April 1, 2003) at 7 (citing, as part of reason 1, Franchise Tax Board v. Construction Laborers Vacation Trust, 463 U.S. 1, 25 (1983) which states that "Congress did not intend to preempt entirely every state cause of action relating to [ERISA] plans" because it expressly does not exempt plans from any state laws that regulate insurance). In the instant cases, the state law claims are based on statutory causes of action specifically codified by the Texas legislature.

[27] ERISA provides only that it "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).

[28] Bogan, at n.29 (again citing Franchise Tax Bd., 463 U.S. at 25. Professor Bogan also states that many district courts have recognized that express preemption under ERISA § 514 does not preempt state tort claims. Id. at 3-4 and n.16 (citing this Court's decision in New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995)).

[29] See id. at 11 (explaining this language as reason no. 10 of his "fifteen incontrovertible reasons").

Notably, in the text of the statute, "hospital" appears only once and "physician" not at all.[30] This Court has stated that "[n]othing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern."[31]

The absence of language specifically preempting state law claims in § 502 is in contrast to the clear language of the McCarran-Ferguson Act. That act specifically states that "No act of Congress shall be construed to invalidate ... any laws enacted by any State for the purpose of regulating the business of insurance."[32] Further, § 514 expressly states that it shall not be construed to supersede any other federal law.[33]

Moreover, the very preamble of ERISA provides that it is intended to protect employees.[34] Petitioners'

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[30] Billie Elliott McAuliffe, *The Changing World of HMO Liability Under ERISA*, 22 J. LEGAL MED. 77, 86 (March 2001).

[31] Travelers, 514 U.S. 645, 661, 115 S. Ct. 1671, 1679-80. See also Pegram, 530 U.S. at 235, 120 S. Ct. at 2157-58. Amicus believes that this necessarily includes both sections 502(a) and 514, as argued by the Respondents in these consolidated appeals.

[32] 15 U.S.C.A. § 1012(b) (West 2003). See Sharon J. Arkin, *Memorandum Re: California Bill SB21* (2001), available at http://www.harp.org/arkin.htm, (stating that ERISA health plan administrators, such as MCOs and HMOs, already are subject to numerous state law regulations despite ERISA's preemption provisions).

[33] Bogan, at 11 (explaining as reason 11 that ERISA does not and cannot supersede the McCarran-Ferguson Act that specifically reserves state law tort claims, such as the ones at issue in this case, to the powers of the various states).

[34] Bogan, at 12-13 (stating that ERISA's preamble, and its legislative history, confirm that it is intended to help assure plan participants actually received the benefits they were led to believe they would receive).

arguments ignore that intention. The limited protection provided to health insurers and health plans is based on contractual, not tort, duties and that protection is not intended to supplant traditional tort-based duties or standards of care.[35]

C. This Court's Reasoning Has Assumed The Availability To Enrollees Of State Law Tort Claims

This Court has recognized that the business model of health insurers and health plans creates an incentive to deny expensive treatments and prescribe the least expensive alternatives.[36] This Court has described how health insurers and health plans often provide similar incentives to doctors with the lowest cost per patient.[37] Further, that incentive runs counter to any duty to consider the enrollee's treatment as the first priority.

> The fiduciary is, of course, obligated to act exclusively in the interest of the beneficiary, but this translates into no rule readily applicable to HMO decisions .... While the incentive of the HMO physician is to give treatment sparingly, imposing a fiduciary obligation upon him would not lead to a simple default rule...[38]

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[35] Cicio, at 99 (citing Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 147-48 (1985); Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113, 109 S. Ct. 948 (1989) and Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 138, 111 S. Ct. 478 (1990)).

[36] See Pegram, 530 U.S. at 223, 120 S. Ct. at 2151.

[37] See id. at 219, 120 S. Ct. at 2149 (describing how HMOs are designed to reward physicians financially for providing less treatment and for providing less expensive treatment).

[38] Id. at 234, 120 S. Ct. at 2157.

This Court went on to state that that ERISA does not create for enrollees a fiduciary claim against HMOs since, "for all practical purposes, every claim of fiduciary breach by an HMO physician making a mixed [eligibility and treatment] decision would boil down to a malpractice claim."[39] That explanation assumes the availability of state tort claims that may be used to make whole an enrollee who was improperly denied medical treatment.

Having closed the door on a federal, ERISA based remedy that allows enrollees to recover the full value of damages they suffered, this Court cannot adhere to its own reasoning if it now decides to limit enrollees' ability to bring state tort claims, such as malpractice claims.

D. State Legislatures Across The Nation Also Have Recognized The Inherent Need For Tort Law Protection Of ERISA Enrollees

In recent years, policymakers and regulators across the country have recognized, formally, that utilization review constitutes medical decision-making. For example, the AMA's current policy on the topic is "that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine."[40]

State regulators are increasingly in accord. For example, in 1997, the Texas State Board of Medical

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[39] Id., at 235, 120 S. Ct. at 2157.

[40] AMA Policy H-285.939, Managed Care Medical Director Liability. Available online at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/HnE/H-285.939.HTM&s_t=H-285.939&catg=AMA/HnE&catg=AMA/BnGnC&catg=AMA/DIR&&nth=1&&st_p=0&nth=1&. The concept of "the practice of medicine" is analogous to the concept in Pegram of "treatment decisions" and "mixed treatment and eligibility decisions." See Pegram, 530 U.S. at 235, 120 S. Ct. at 2154.

Examiners decided that "the determination of medical necessity or appropriateness of proposed care so as to effect the diagnosis or treatment of a patient is the practice of medicine."[41] In 1998, the California State Medical Board passed a resolution that "the making of a decision regarding the medical necessity. . . of any treatment constitutes the practice of medicine."[42]

In 1999, the Louisiana State Board of Medical Examiners held that "the requirement that the act of determining medical necessity or appropriateness of proposed medical care so as to effect the diagnosis or treatment of a patient in Louisiana is the practice of medicine."[43] Also, in 2001, the South Carolina Board of Medical Examiners declared that "the act of determining medical necessity or appropriateness of proposed medical care, so as to affect the diagnosis or treatment of a patient located in South Carolina, is the practice of medicine."[44]

More regulation of this type is likely, as such regulation is expressly advocated by the Federation of State Medical Boards of the United States, Inc. In 1998, this entity advised its membership, which includes the medical boards of all states and the District of Columbia, that "[s]tate medical boards, through legislative or regulatory process, should amend their medical practice acts or appropriate statutes to include the determination of medical necessity or

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[41] Texas State Board of Medical Examiners, Medical Board Report, Vol. 18, No. 2 (Spring 1997), available at http://www.tsbme.state.tx.us/news/Spring97/spring97.htm.

[42] See Silicon Valley San Jose Business Journal, June 5, 1998.

[43] See La. Op. Att'y Gen. No. 98-491, 1999 WL 288869, p.2 (Apr. 27, 1999).

[44] See Policy Statement approved at February 5-7, 2001 Board Meeting, available at www.llr.state.sc.us/POL/Medical/Medical%20Necessity.htm.

decisions affecting the diagnosis and/or treatment of a patient as the practice of medicine."[45]

Many states have begun to regulate health insurers and health plans, like MCOs and HMOs, more closely. [46] For example, Minnesota passed a law establishing that its Board of Medical Practice has jurisdiction to take action against utilization review physicians whose judgments violate the standard of care.[47] And, in 1995, the Florida Agency for Health Care Administration issued a cease and desist order against Roger Strube, a medical director of a Florida-based managed care organization. It alleged that he practiced medicine without a license in Florida by making utilization review decisions.[48] This agency decision appears to turn on facts analogous to those here, where a nurse at CIGNA refused to accept a treating physician's recommendation and prescribed other treatment.

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[45] Report of the Special Committee on Managed Care, S III.C., (May 1998), available at www.fsmb.org.

[46] Barry Gold, *Vulnerability of HMO Physicians Who Make Medical Necessity Decisions to Professional Misconduct Proceedings by State Licensing Agencies*, Presentation at New York State Bar Assn. Annual Convention (Jan. 26, 2000); see also National Conference of State Legislatures, *Major Health Care Policies: 50 State Profiles, 2001* (Jan. 2002) at 4 (listing Colorado, Florida, Iowa, Illinois, Kansas, Louisiana, Maryland, Massachusetts, Michigan Minnesota, Missouri, Montana, New Jersey, New York, North Carolina, Rhode Island, Tennessee and West Virginia as states considering statutory liability for health insurers and health plans). During 2001 alone, New Jersey, North Carolina and West Virginia adopted such laws. Id.

[47] 2001 Minn. Laws 147.091, Subd. 1b.

[48] See Agency for Health Care Administration, Notice to Cease and Desist, at 1, In re Unlicensed Practice of Med.: Roger H. Strube, No. 9420668 (filed Feb. 24, 1995). The Agency did so even though Dr. Strube was licensed in two other states.

Some courts also have addressed cases arising from such state laws, and allowed them to proceed.[49] The Missouri Supreme Court cited Murphy with approval in evaluating the state medical board's jurisdiction over a medical director who propounded pre-certification decisions.[50] That court expressly found that jurisdiction was proper because the medical director's decisions were not administrative but medical:

> The determinations at issue in this case fall outside the scope of plan administration. Dr. Fallon did not simply look to a predetermined list of covered procedures to arrive at his conclusions. He used medical training and judgment to make a decision about the "medical necessity" of surgical treatment for a particular patient.[51]

Other states have begun to consider the passage of legislation that would increase the requirements placed upon HMOs.[52] For example, the State of New York announced in 1998 that the Office of Professional Medical Conduct will investigate complaints regarding denials of care made by medical directors of managed care organizations.[53]

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[49] See e.g., Murphy v. Board of Medical Examiners, 949 P.2d 530 (Ariz. App. 1997), in which the Arizona Court of Appeals ruled that the State Board of Medical Examiners had jurisdiction over a state-licensed physician who denied pre-certification for gallbladder surgery, on behalf of a managed care organization.

[50] State Board v. Fallon, 41 S.W.3d 474 (2001).

[51] See 41 S.W.3d at 478.

[52] See The Limited Liability of Corp. Health Maintenance Org., 39 Dec. TNBJ 27, 35 (Dec. 2003)(listing Arizona, California, Georgia, Maine, Massachusetts, North Carolina, Oklahoma, Texas and Washington).

[53] MSSNY, News of New York, Oct. 1998, p.5.

In addition, a majority of states, including New York, have passed legislation requiring medical directors of managed care organizations to be licensed as physicians.[54] Such legislation is significant because it puts the lie to the contention that utilization review regards coverage alone. If that were true, then there would be no need for the "utilization reviewers" to be licensed physicians. Thus, the Medical Society of the State of New York ("MSSNY") and other organizations call for regulations that:

> [w]i.. declare that any person making decisions on the medical necessity or appropriateness of care affecting the diagnosis or treatment of a patient in New York must have a license to practice medicine in New York; and that a physician making decisions on the medical necessity or appropriateness of care affecting the diagnosis or treatment of a patient in New York without a valid New York license, as well as the company that employs him/her, will be subject to investigation, criminal prosecution and possible fines.[55]

In addition to New York, states with such laws include Alabama, Arizona, Arkansas, California, Colorado,

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[54] Tanya Albert, "Higher Accountability for HMO Medical Directors," amednews.com (May 14, 2001), available at http://www.ama-assn.org/amednews/2001/05/14/prl20514.htm ("In the past several years, more than half of the nation's stat· have passed laws requiring HMO medical directors to be licensed physicians. And medical directors who are licensed physicians are increasingly being held responsible by state medical boards." In fact, the Federation of State Medical Boards mandates the passage of such legislation. See n.14, supra, at III.D ("State medical boards must, through legislative or regulatory process, require that MCO medical directors hold current and unrestricted medical licenses in the states in which the patients of the plan reside").

[55] MSSNY Position Statement § 165.969, available at http://www.mssny.org/position/managed.htm (Jan. 21, 2004).

Delaware, Florida, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maryland, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Rhode Island, South Dakota, Texas, Vermont, Virginia and Wisconsin.[56]

Finally, this Court made clear in Pegram that a number of states permit malpractice actions against HMOs, and that such actions are consistent with ERISA.[57] In recent years, five states - Texas, Georgia, California, Arizona and Washington - have passed laws expressly giving consumers expanded rights to sue their HMOs. Other states actively are debating similar legislation.[58]

These policies, regulations, laws and decisions collectively illustrate decisions such as those made by Aetna and CIGNA in these cases are widely considered to involve the practice of medicine, and "mixed eligibility and treatment decisions." Semantics aside, the outcome is clear. The decisions are subject to liability under state law and fall outside the scope of preemption.

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[56] See National Conference of State Legislatures, *Major Health Care Policies: 50 State Profiles, 2001* (Jan. 2002) at 28-31, Table 2, and passim in the state sections. See also *Major Health Care Policies*, at 4 (listing New Jersey, North Carolina and West Virginia as having adopted statutes during 2001 that afford direct liability against health insurers and health plans for treatment decisions).

[57] Pegram, 530 U.S. at 236, 120 S. Ct. at 2158. In fact, one reason the Court offered for failing to recognize a breach of fiduciary action under ERISA was that such an action could be seen as "a prescription for preemption of state malpractice law. . . ." As shown by Pappas and Vytra supra, such cases have proceeded under state common law in state and federal courts.

[58] Phyllis C. Borzoi, *Erisa and Managed Care Plans: Key Preemption and Fiduciary Issues*, SF28 ALI-ABA 371 (Oct. 2000) at 423 n.2.

III. STATE LAW TORT CLAIMS ARE NECESSARY TO DETER WRONGFUL DENIALS OF MEDICAL TREATMENT AND HEALTH CARE

A. Health Insurers and Health Plans Receive The Same Payment For Their Product Whether Or Not They Deny Treatment

Unlike most products, after health insurance policies and plans are sold, the buyer wants it to work, but the seller does not.[59] Health insurance policies and health plans are aleatory, meaning that the enrollee performs first, by paying premiums while the health insurer or health plan performs later, but only if a claim for treatment is made.[60] The nature

[59] "Unlike most other commercial actors fighting for supremacy in a world where possession is nine-tenths of the law, insurers always have the nine-tenths advantage: They hold the money. Consequently, insurers always get to "play the float" in any dispute." Jeffrey W. Stempel, *Interpretation of Insurance Contracts: Law and Strategy for Insurers and Policyholders*, § 19.3, at 466-67 (1994).

[60] Comparing the insurance transaction to purchasing a car highlights the difference. When one contracts for a Cadillac, and is tendered a Yugo, one may cancel her check and go to another car dealership. An enrollee, however, who is promised Cadillac insurance at the point of sale and receives Yugo insurance at the point of treatment cannot "recover" by going back in time.

of the contract provides the insurer or plan with a future advantage, namely, economic leverage.[61]

Prior to the time of treatment, it is difficult to evaluate the quality of the health insurer or health plan. As explained above, at the time of treatment, an enrollee is at a distinct economic disadvantage already having "lost" the premium, unable to independently afford the medical treatment and already being ill. Time is often crucial to the enrollee needing treatment, while the health insurer or health plan may comfortably use time to its advantage.[62]

As in the case of Mr. Cicio, the patient may not even live to see the outcome of his lawsuit against his health insurer and health plan.[63] If an enrollee's potential damages were capped at the cost of the treatment denied, it could be pointless to file a lawsuit.

[61] Pegram states this principle as it is applied to an HMO, rather than a traditional insurance company:

> The defining feature of an HMO is receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed. The HMO thus assumes the financial risk of providing the benefits promised: *if a participant never gets sick, the HMO keeps the money regardless,*...cost-controlling measures are commonly complemented by specific financial incentives to physicians, *rewarding them for decreasing utilization of health-care services, and penalizing them for what may be found to be excessive treatment,* ...

Pegram, 530 U.S. at 219, 120 S. Ct. at 2149 (citation omitted)(emphasis added).

[62] See Cicio v. John Does 1-8, et al., 321 F.3d 83, 87-88 (2d Cir. 2003)(detailing the health plan enrollee's missed opportunity to receive particular treatment because the insurance company would only communicate with the enrollee's physician by letter and required three weeks to a month to respond to each letter). In Cicio, the enrollee actually passed away prior to the resolution of his lawsuit.

[63] Cicio, 321 F.3d at 88.

The heavily tilted playing field favoring health insurers and health plans has not gone unnoticed by courts. Even the dissent in Cicio recognized that inherent injustice that would result if enrollees had no ability to seek compensatory damages when health insurers or health plans improperly denied treatment. "The conclusion that my colleagues have reached … [that her tort claims are not preempted]. may provide justice to Mrs. Cicio, and I'm glad for that...."[64]

The instant cases now provide this Court a valuable opportunity to make clear to everyone who is enrolled in an ERISA plan, along with the entire health insurance industry, that state laws – including both statutory and common law – are available to protect enrollees under ERISA against wrongful actions by health insurers and health plans.

B. Health Insurers and Health Plans Could Use "Opportunistic Breaches" To Their Advantage, Without A State Law Remedy

Without the threat of compensatory damages, health insurers and health plans would be free to delay or treatment and prescribe less expensive treatment without any consequences. In fact, a practice of institutionalizing wrongful denial would be a rational business plan, as it would maximize profits and minimize costs. Such a scenario would run completely counter to the intent of Congress in creating ERISA: the protection of employees.[65]

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[64] Cicio, 321 F.3d at 106 (Calabresi, J. dissent).

[65] Cicio, 321 F.3d at 99 (stating that "Indeed, one of ERISA's stated goals involves increasing 'the likelihood that full benefits will be paid to beneficiaries…")(citing 29 U.S.C. § 1001b(b)(1)); see also Bogan, at 7 n.31 (citing, as part of reason 2, Humana v. Forsyth, 525 U.S. 299, 312, 119 S. Ct. 710, 718 (1999) for the proposition that ERISA is intended to protect employees and, therefore, there can be no preemption of state law tort claims that are (inherently) extra-contractual, because they supplement ERISA's protection of employees rather than conflict with it).

It is well recognized that health insurers and health plans increase profits by delaying and denying claims and that by delaying and denying claims those companies may be exercising "opportunistic breaches."[66] Opportunistic breaches are precisely what enrollees would be forced to endure if they could not bring tort claims against health insurers and health plans that wrongfully delay or medical treatment under ERISA plans. Health insurers and health plans, along with their senior executives,[67] would have every incentive to delay or claims under that scenario.

CONCLUSION

The party that holds the purse strings, whether a traditional insurance company or a managed care organization, should not be permitted to be the ultimate arbiter of its own self-interested decisions. It is a poor idea, and possibly a fatal own, to give such entities complete autonomy, along with a financial incentive to delay or claims and a lack of financial exposure for any consequences. State tort laws – both statutory and common law – provide a much-needed antidote, and the instant cases provide an opportunity for this Court to apply it. For all of these reasons, *Amici* respectfully urge this Court to render a decision establishing that state tort law claims are not preempted by ERISA. *Amici* respectfully suggest that the judgment of the United States Court of Appeals for the Fifth Circuit should be affirmed.

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[66] Since insurance companies have an incentive to force litigation to lower overall claim payments, "[o]pportunistic breaches are especially likely, and traditional damage rules do not sufficiently deter them." Pennington, *Punitive Damages for Breach of Contract: A Core Sample from the Decisions of the Last Ten Years*, 42 Ark. L. Rev. 31, 54 (1989).

[67] Pegram, 530 U.S. at 219, 120 S. Ct. at 2149 (explaining that HMOs make a profit by providing less treatment and charging fixed fees). Thus, any employees of an HMO whose compensation is tied to profits has an incentive to provide the least expensive care to patients.

Respectfully submitted,

Eugene R. Anderson
Counsel of Record
Anderson Kill & Olick, P.C.
Rhonda D. Orin
Daniel J. Healy
Anderson Kill & Olick, LLP
2100 M Street, N.W., Suite 650
Washington, DC 20037

David L. Trueman
18 East 50th Street
7th Floor
New York, NY 10022

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